45th day / 70th day
11-25-17 / 12-20-17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #2	445124	A. BUILDING _____ B. WING _____	10/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF GALLATIN, LLC	555 EAST BLEDSOE STREET GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #40360, #41301, #41529, #41809, #41885 and #42449 were completed on 10/9/17-10/11/17 at The Waters of Gallatin. Deficiencies were cited related to the recertification survey and complaint investigation #41809 and #41885, under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 223 SS=D	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to prevent abuse/exploitation for 1 residents (#81) of 5 resident reviewed for abuse. The findings included: Review of facility policy, Cell Phone Policy, undated, revealed "...It is Facility's policy that representatives of our organization do not use	F 223	**F 223 483.12(a)(1)** 1.Physical assessment completed on resident # 81 by attending physician and medical director with findings noted. Q 15 minute checks initiated until cleared by NP on 06.27.2017 @ 1:00. SW assessed resident, completed BIMS score 14, PHQ4 score 4/27.Residents physically assessed by licensed nursing personnel throughout day with resident noted to be happy, joking with staff, and on IPad. Skin assessment completed by ADON on 06.27 with no new findings. Care plan revised on 06.27.2017 by MDS Coordinator to reflect resident condition. Psychologist evaluation on 06.28.2017 with no distress noted. SW continued to follow resident for how long for three days to monitor for any changes in mood or signs and symptoms of psychological distress.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/30/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 cell and /or smart phones while performing work tasks. Further, video and or pictures should not be taken of residents, PHI [Protected Health Information] and ePHI [electronic Protected Health Information]..." Medical record review revealed Resident #81 was admitted to the facility on 11/11/16 and readmitted on 7/15/17 with diagnoses including Displaced Supracondylar Fracture with Intracondylar Extension of Lower End of Left Femur, Dyspnea, Chronic Obstructive Pulmonary Disease, Acute on Chronic Combined Systolic and Diastolic Heart Failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Atrial Fibrillation, Chronic Pain Syndrome, Heart Failure, Pleural Effusion, Gastroparesis, Hyperlipidemia, Panic Disorder, Major Depressive Disorder, Anxiety Disorder, Hypertension, Irritable Bowel Syndrome and Gastro-Esophageal Reflux Disease without Esophagitis. Resident #81 discharged from the facility on 7/28/17. Medical record review of the Quarterly Minimum Data Set dated 6/28/17 revealed the resident had a Brief Interview for Mental Status score of 15, indicating she was cognitively intact. Review of the facility investigation revealed a written statement from Certified Nurse Aide (CNA) #2 dated 6/27/17 "...I was shown a picture by [CNA #1]. It was an inappropriate picture of the resident in 408B. I also witnessed [CNA #1] showing the picture at the nurse's station one night & laughing about it..." Telephone interview with CNA #1 on 10/11/17 at 6:35 PM revealed she admitted taking a picture of Resident #81 while the resident was transferring	F 223	**2.**All residents have the potential to be affected by this practice. On 06.27.2017 all residents were interviewed by department heads utilizing Abuse Questionnaire. No concerns were identified. All residents received a skin assessment on 06.27.2017, no concerns were identified. All staff were interviewed nursing administration and Administrator regarding abuse and neglect using the Abuse Questionnaire. Interviews included any knowledge of incident. No new reports of abuse were identified. **3.**On 06.27.2017, 100% of staff trained Administrator and nursing administration on Abuse with completion of abuse competency test with 100% pass rate required. On 06.27.2017, 100% of staff were interviewed on abuse and neglect using the Abuse Questionnaire with no new findings. On 06.27 and	

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2.1

EMPLOYEE NAME	POSITION	ABUSE	CELL PHONE	SOCIAL MEDIA	HIPPA	STAFF QUESTIONNAIRE	DIGNITY, RESPECT, CUSTOMER SERVICE
Adams, Tierra	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Adams, Valaurie	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Adams, Virginia	DIETARY AIDE	6/27	6/27	6/27	6/27	6/27	6/28
Alguire, Lori	LPN	REFUSED	6/27	6/27	REFUSED	6/27	REFUSED
Ashworth, Tina	SOCIAL SERVICES	6/27	6/27	6/27	6/27	6/27	6/28
Blackwood, Sherrie	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Blake, Sarah	ST	6/27	6/27	6/27	6/27	6/27	6/28
Byram, Jana K.	DON	6/26	6/26	6/27	6/26	6/27	6/28
Byrd, Melissa	RN	6/27	6/27	6/27	6/27	6/27	6/30
Cantrell, Shelia	CLERICAL/PAYROLL	6/27	6/27	6/27	6/27	6/27	6/28
Chastian, Margie	LPN	6/27	6/27	6/27	6/27	6/27	6/29
Clay, Montrea	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Cook, Christie	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Cooper, Destiney N	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Copass, Phyllis	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Crain, Tony	MAINTENANCE DIR	6/27	6/27	6/27	6/27	6/27	6/28
Cross, Rita	TRANSPORTATION	6/27	6/27	6/27	6/27	6/27	6/28
Dabio, Mindy	OT	6/28	6/27	6/27	6/28	6/27	6/28
Dalton, Sharl	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Davenport, Jamie	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Dell'Aquila, Johnna	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Dixon, Madelyn Rochelle	OFFICE MANAGER	6/27	6/27	6/27	6/27	6/27	6/28
Douglas, Sonya	CNA	6/28	6/28	6/28	6/28	6/28	6/28
Esquivel, Jeannie	HSKP SUPERVISOR	6/27	6/27	6/27	6/27	6/27	6/28
Faulton, Lois	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Foshee, Jeniffer	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Getchel, Danielle	MDS	6/27	6/27	6/27	6/27	6/27	6/28
Gleaves, Jeraldean	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Gooch, Charla	LPN	6/27	6/27	6/27	6/27	6/27	6/29
Goostree, Kelsey	CNA	6/27	6/27	6/27	6/27	6/27	6/28

EMPLOYEE NAME	POSITION	ABUSE	CELL PHONE	SOCIAL MEDIA	HIPPA	STAFF QUESTIONNAIRE	DIGNITY, RESPECT, CUSTOMER SERVICE
Grissom, Bryan	PT	6/28	6/27	6/27	6/28	6/27	6/28
Grizzard, Janie	DIETARY AIDE	6/27	6/27	6/28	6/27	6/27	6/28
Gross, Kathy	DIETARY DIRECTOR	6/27	6/27	6/27	6/27	6/27	6/29
Haapala, Carrie	RSM	6/27	6/27	6/27	6/27	6/27	6/28
Haile, Peggy	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Hall, Darneka	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Haper, Linda	ACTIVITY AIDE	6/27	6/27	6/27	6/27	6/27	6/28
Harris, Ashley	DIETARY DIRECTOR	6/27	6/27	6/27	6/27	6/27	6/28
Harris, Lisa	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Haviland, Bonnie	COOK	6/27	6/27	6/27	6/27	6/27	6/28
Henry, Phillip	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Honeycutt, Carolyn Renea	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Hoskins, Christy	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Howard, Moffitt Verica	RN	6/27	6/27	6/27	6/27	6/27	6/28
Christian, Renard	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Humphrey, angelitio	COOK	6/28	6/28	6/28	6/28	6/28	6/28
Jenkins, Marchell	DIETARY AIDE	6/27	6/27	6/27	6/27	6/27	6/28
Joaque, Lucy	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Johnson, Dominque	CNA	6/28	6/27	6/27	6/28	6/28	6/28
Jones, Karen	MEDICAL RECORDS	6/27	6/27	6/27	6/27	6/27	6/28
Layne, Amy	LPN	6/27	6/27	6/27	6/27	6/27	Resigned 6/29
Layne, Tammy	CNA	6/27	6/27	6/27	6/27	6/27	6/28
[redacted]	PT	6/28 MAIL	6/27	6/27	6/28 MAIL	6/27	6/28
Litts, Vickie	RN	6/27	6/27	6/27	6/27	6/27	6/28
Locke, Bettye	MDS	6/27	6/27	6/27	6/27	6/27	6/28
Loftis, Robert	COTA	6/27	6/27	6/27	6/27	6/28	6/28
Long, Maria	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Malone, Burnell	REHAB AIDE	6/27	6/27	6/27	6/27	6/27	6/29
Manier, Donner	ACTIVITY DIRECTOR	6/27	6/27	6/27	6/27	6/27	6/28
Martin, Robin	CNA	6/27	6/27	6/26	6/27	6/27	6/28
McDonald, Anna	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28

EMPLOYEE NAME	POSITION	ABUSE	CELL PHONE	SOCIAL MEDIA	HIPPA	STAFF QUESTIONNAIRE	DIGNITY, RESPECT, CUSTOMER SERVICE
Mikkelsen, Erika	PT	6/27	6/27	6/27	6/27	6/27	6/28
Moore, Judy	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Morris, Cynthia Hasking	OT	6/27	6/27	6/27	6/27	6/27	6/28
Morrison, Sally	PTA	6/27	6/27	6/27	6/27	6/27	6/28
Newman, Ida	LPN	6/27	6/27	6/27	6/27	6/27	6/29
Overall, Danielle Lexie	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Overman, Judy	LPN	6/27	6/27	6/27	6/27	6/27	6/30
Peek, Elizabeth	CNA	6/28	6/28	6/28	6/28	6/28	6/28
Rand, Trevor	LPN	6/27	6/27	6/26	6/27	6/27	6/28
Reynolds, Jennifer	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Roberts, Patricia	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Satterfield, Sharon	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Shelton, Dawn Michelle	COOK	6/27	6/27	6/27	6/27	6/27	[redacted] 6/30/17
Sisco, Angela	LPN	6/28	6/26	6/26	6/28	6/27	6/29
Smiley, Delia	ADMISSION DIR	6/26	6/26	6/26	6/26	6/27	6/29
Smith, Joyce L.	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Spencer, Lisa	PT	6/28	6/27	6/27	6/28	6/27	6/28
Sollinger, Kevin	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Steitler, Hannah	ST	6/27	6/27	6/27	6/27	6/27	6/28
Stevens, Jamie	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Stewart, Rita Annette	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Sweat, Jennifer	CNA	6/27	6/26	6/27	6/27	6/28	6/28
Thieme, Jennifer	DIETARY AIDE	6/28	6/28	6/28	6/28	6/27	6/30
Toney, Amy	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Wheeler, Amanda	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Williams, Larry	PTA/TC	6/28	6/27	6/27	6/28	6/27	6/28
Williams, Pam	ST	6/28	6/27	6/27	6/28	6/27	6/28
Williams, Priscilla	LAUNDRY	6/27	6/27	6/27	6/27	6/27	6/28
Williams, Trina	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Willmore, Robin	ADMINISTRATOR	6/28	6/28	6/28	6/28	6/28	6/28
Wood, Therese P	LPN	6/28	6/26	6/26	6/28	6/27	6/29
Woodard, April	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Yeagar, Laura	DOR	6/27	6/27	6/27	6/27	6/27	6/28

Staff Questionnaire

Staff Name: _____ ____ **Date:**_____

1. **Have you or do you know if anyone has ever taken any pictures of a resident?**

2. **Have you or do you know of anyone posting residents pictures or information on any social media?**

3. **Have you ever witnessed any type of abuse toward a resident in this facility?**

4. **Have you or do you know of any staff member that has violated the Personal Health Information(PHI) policy in regards to any resident in this facility**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 223	Continued From page 2 from the bedside commode to the bed. It was unknown when this picture was taken. Further interview revealed the resident was not clothed from the waist down. Further interview revealed approximately 2 months later the CNA sent the picture to CNA #2 and denied showing the picture to any other staff. Interview with the Administrator on 10/11/17 at 4:30pm in her office revealed confirmed the facility failed to prevent abuse/exploitation for Resident #81.	F 223	Any identified concerns will be immediately reported to the administrator with follow up completed as appropriate. Department Heads will audit staffs cell phone compliance daily during room rounds, documenting on Room Rounds Form. Any concerns will be immediately reported to the Administrator/designee with Immediately action as required.	
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225	**F 225 483.12 (a)(3)(4)(c)(1)-(4)** **1.** On June 27, the Director of Nursing interviewed Resident # 81 and secured a statement regarding the incident and placed in the investigative file. 100% of staff were interviewed on 06.27.2017 by nursing administration regarding abuse and neglect allegation related to missing money with no new findings. Results were placed in the investigative file. Administrator, Director of Nursing, and Assistant Director of Nursing received training on Abuse Reporting and	

THE WATERS OF GALLATIN – In-Service Record

Date: 06.27.2017

Subjects covered:

Abuse investigation and reporting guidelines - 1:1 w Rick Mountz, RVP

PRINT NAME	SIGNATURE	TITLE	SHIFT
Robin Willman	RWillman	Admin	

THE WATERS OF GALLATIN – In-Service Record

Date: 6/29/17

Subjects covered:

Abuse reporting protocol

PRINT NAME	SIGNATURE	TITLE	SHIFT
Christy Hoskins		ADON	
Jana Byram	Jana Byram, RN	DON	

6/29/17

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F 225	Continued From page 3 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	Conducting Investigations on 06.27 and 06.29 by the regional consultants. 2.All residents have the potential to be affected by this practice. 100% of residents with BIMS > 9 and or family members were interviewed by social worker to ensure no unreported abuse with no new findings. 100% of staff were educated on abuse and neglect by nursing administration on 06.27 and 07.13 then administered an Abuse Competency Test with 100% pass rate. to ensure comprehension. Skin assessments were completed on 06.27.2017 by ADON on residents with BIMs of < or equal to 8 with no new findings. 3.Administrator, Director of Nursing, and Assistant Director of Nursing were trained on 6.27+6.29 regional consultants on Abuse Investigation and Reporting. Abuse checklist was reviewed and to be utilized in all investigations.	

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to thoroughly investigate 2 allegations for 1 resident (#81) of 5 residents reviewed for abuse. The findings included: Review of facility policy, Abuse Prevention Program, dated 1/19/17 revealed "...Once the Administrator or designee determines that there is a reasonable cause for suspecting abuse, the Administrator or designee will investigate the allegation and obtain a copy of any documentation relative to the incident..." Medical record review revealed Resident #81 was admitted to the facility on 11/11/16 and readmitted on 7/15/17 with diagnoses including Displaced Supracondylar Fracture with Intracondylar Extension of Lower End of Left Femur, Dyspnea, Chronic Obstructive Pulmonary Disease, Acute on Chronic Combined Systolic and Diastolic Heart Failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Atrial Fibrillation, Chronic Pain Syndrome, Heart Failure, Pleural Effusion, Gastroparesis, Hyperlipidemia, Panic Disorder, Major Depressive Disorder, Anxiety Disorder, Hypertension, Irritable Bowel Syndrome and Gastro-Esophageal Reflux Disease without Esophagitis. Resident #81 discharged from the facility on 7/28/17. Medical record review of the Quarterly Minimum Data Set dated 6/28/17 revealed Resident #81 had a Brief Interview for Mental Status score of 15, indicating she was cognitively intact.	F 225	4. The Nurse Consultant will audit all Reportable Events utilizing the Abuse Investigation Checklist to ensure Abuse Investigations are thoroughly investigated and reporting policy and checklist are followed for three months, then forwarded to QAPI Committee for review and recommendation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING _____ B. WING _____	10/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 5 Review of the facility investigation regarding abuse/exploitation of Resident #81 revealed no statement from the identified staff who took the picture or from Resident #81. Review of the facility investigation of an undated hand written document revealed "...Res [resident] reported to nurse that $80 was missing fr [from] wallet. It has been 2-3 days since she saw it..." Further review of the facility's investigation revealed 5 witness statements were obtained from staff. Interview with the Administrator on 10/11/17 at 4:30 PM in her office revealed the resident was having hallucinations when she reported the money missing. The Administrator stated the hallucinations worsened as the day progressed, resulted in the resident being sent to local hospital for evaluation. The Administrator confirmed no additional witness statements were obtained nor was a statement obtained from Resident #81. The Administrator confirmed she wrote the hand written document in the investigation. The Administrator confirmed the facility failed to thoroughly investigate 2 allegations of abuse/exploitation and misappropriation of funds for Resident #81. Interview with the Assistant Director of Nursing (ADON) on 10/11/17 at 4:45 PM in the conference room revealed the statements in the investigations were obtained by the Director of Nursing, the Administrator and the ADON. The ADON confirmed no additional statements were obtained from any additional staff, from the identified staff who took the picture of Resident #81 or from Resident #81 about either investigation. The ADON confirmed the facility	F 225		

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F 225	Continued From page 6 failed to thoroughly complete both investigations. The facility failed to obtain statements from staff who worked prior to the money being reported missing and from Resident #81 thus the facility failed to completed a thorough investigation of the missing money per the facility. The facility failed to obtain statements from the identified staff who took the picutre of Resident #81 and from the resident thus the facility failed to complete a thorough investigation of abuse/exploitation per the facility policy.	F 225		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278	**F-278 483.20 (g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED** **1**Resident #34 was scheduled and assessed by the Dentist on 10.13.2017. Care plan was updated by the Minimum Data Set Nurse (MDS) as needed on 10.20.2017 The Minimum Data Set (MDS) Nurses were trained on Section L, "Oral/Dental Status", on 10.24.17 by the Regional MDS Registered Nurse. **2**All Residents have the potential to be affected by this practice. Oral Assessments were completed on residents by the Licensed MDS Nurses by 10.20.17. Residents identified with oral concerns were communicated to the physician and	10/24/17

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F 278	Continued From page 7 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accurately assess the oral status of 1 resident (#34) of 20 residents reviewed. The findings included: Medical record review revealed Resident #34 was admitted to the facility on 3/31/09 and readmitted on 9/8/09 and 11/9/15 with diagnoses including Alzheimer's Disease, Abnormal Posture, Urinary Tract Infection, Autonomic Neuropathy in Diseases, Restless Legs Syndrome, Vitamin D Deficiency, Acquired Hemolytic Anemia, Anxiety Disorder, Major Depressive Disorder, Dementia without Behavioral Distrubance and Hypertension. Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/7/17, the Annual MDS dated 5/5/17, and the Quarterly MDS dated 8/2/17 of the Oral/Dental Status section revealed the resident had no concerns. Observation on 10/10/17 at 9:53 AM in the Main Dining Room, on 10/10/17 at 12:40 PM in the 600	F 278	dental appointments scheduled for follow up. Care plans will be updated as needed. 3MDS Nurses were trained by the Regional MDS Nurse on Section L, "Oral/Dental Status", on 10.24.17. The MDS Consultant will Audit 10% of Comprehensive MDS Assessments monthly for 3 months to ensure accurate coding effective 10.25.17. Any concerns identified will be immediately addressed with reeducation, correction and communicated to the Administrator. 4The MDS Consultant will Audit 10% of Comprehensive MDS Assessments monthly for 3 months to ensure accurate coding. Any concerns identified will be immediately addressed with reeducation, correction and communicated to the Administrator. The results of audits will be forwarded to the Administrator and Director of Nursing for review then forwarded to the QAPI Committee for review and recommendations.	

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F 278	Continued From page 8 Hall area, and on 10/11/17 at 7:20 AM in the 600 Hall dining area revealed Resident #34 had several missing front teeth at the top and bottom of the mouth. Interview with the MDS Corrdinator on 10/11/17 at 12:10 PM in her office revealed she was responsible for completing the dental status section of the MDS for Resident #34. The MDS Cordinator confirmed Resident #34's dental status section on the Quarterly MDS dated 2/7/17, the Annual MDS dated 5/5/17 and the Quarterly MDS dated 8/2/17 were not coded accurately.	F 278		
F 516 SS=D	RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS CFR(s): 483.20(f)(5)(i)(ii); 483.70(i)(3) 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to safeguard medical record information against loss or	F 516	**F-516 483.20 (f) (5)(i)(ii); 483.70(i)(3)** **RELEASE RESIDENT INFORMATION, SAFEGUARD** **CLINICAL RECORD** 1On 10.10.17 at 4:02 PM the Assistant Director of Nursing secured the controlled substance prescription and educated the licensed nurse on the policy for Controlled Substance Prescriptions emphasizing the importance of maintaining the security of the controlled substance prescriptions by placement of prescriptions into sealed envelopes for delivery to pharmacy. Education was also provide on ensuring the door to the nursing station is locked when licensed staff are not in attendance.	10/25/17

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F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	The HIPAA Policy was reviewed and the importance of securing resident information including the medical record was stressed with emphasis on always logging off of computers and never leaving a computer work station open when unattended. 2On 10.10.17 at approximately 4:30 PM an automatic lock was placed on the nursing station door by the Director of Maintenance. On 10.11.17 the maintenance director applied automatic door closure device to the door. 3All residents have the potential to be impacted by this practice. On 10.10.17 at approximately 4: 10 PM the Director of Nursing and Assistant Director of Nursing immediately conducted audits of all nursing stations and computers to ensure patient information, medical records, and prescriptions for controlled substances were secured properly. No concerns were identified. Facility staff were educated by the Director of Nursing and Assistant Director of Nursing on HIPAA Policy and the importance of maintaining the confidentiality of resident information including the	

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F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	medical record was reviewed. Logging off of computers and never leaving a computer work station open were emphasized. On 10.10.2017 and 10.11.2017 licensed nurses were educated by the Assistant Director of Nursing and Director of Nursing on the policy for Controlled Substance Prescriptions emphasizing the importance of maintaining the security of the controlled substance prescriptions by placement of prescriptions into sealed envelopes for delivery to pharmacy. Education was also provided to ensure the door to the nursing station is locked when licensed staff are not in attendance. The HIPAA Policy was reviewed and the importance of securing resident information including the medical record was stressed with emphasis on always logging off of computers and never leaving a computer work station open when unattended. 4The Director of Nursing or her designee during new Hire Nursing Orientation beginning on 10.25.2017 will provide education to nursing staff on the HIPAA Policy, with emphasis on maintaining	

10.1

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F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	security of resident information. Emphasis will be provided regarding security of the medical records, use of privacy screens for computers, logging off of computers and never leaving a computer work station open when unattended. Privacy screen protectors have been ordered for computers and will be applied to computer screens by 10.25.2017 to improve privacy of residents electronic medical records. Random audits will be completed by the Director of Nursing, Assistant Director of Nursing and the Manager on Duty on weekends beginning 10.25.2017 twice daily for two weeks, then twice weekly for four weeks then weekly for six months, to ensure HIPAA Compliance regarding controlled substance prescriptions, medical record security, use of privacy screens on computers and computers logged off when not in use. Any concerns identified will be	

10.2

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F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	reported to the Administrator and Director of Nursing or designee and addressed immediately with staff reeducation and counseling as appropriate. The results of audits will be forwarded to the Director of Nursing and Administrator for review and follow up then forwarded to the QAPI Committee for review and recommendations.	

10.3

DEPARTMENT OF HEALTH AND HUMAN SERVICES 45 4th day 11-25-17 Amended 2567 / 70th day 12-20-17
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#2	445124	A. BUILDING _____ B. WING _____	10/11/2017

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F 000	INITIAL COMMENTS A recertification survey and complaint investigation #40360, #41301, #41529, #41809, #41885 and #42449 were completed on 10/9/17-10/11/17 at The Waters of Gallatin. Deficiencies were cited related to the recertification survey and complaint investigation #41809 and #41885, under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 223 SS=D	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to prevent abuse/exploitation for 1 residents (#81) of 5 resident reviewed for abuse. The findings included: Review of facility policy, Cell Phone Policy, undated, revealed "...It is Facility's policy that representatives of our organization do not use	F 223	**F 223 483.12(a)(1)** **1.Physical assessment completed on resident # 81 by attending physician and medical director with findings noted. Q 15 minute checks initiated until cleared by NP on 06.27.2017 @ 1:00. SW assessed resident, completed BIMS score 14, PHQ4 score 4/27.Residents physically assessed by licensed nursing personnel throughout day with resident noted to be happy, joking with staff, and on IPad. Skin assessment completed by ADON on 06.27 with no new findings. Care plan revised on 06.27.2017 by MDS Coordinator to reflect resident condition. Psychologist evaluation on 06.28.2017 with no distress noted. SW continued to follow resident for how long for three days to monitor for any changes in mood or signs and symptoms of psychological distress.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: RW Timm
TITLE: Administrator
(X6) DATE: 10/30/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 cell and /or smart phones while performing work tasks. Further, video and or pictures should not be taken of residents, PHI [Protected Health Information] and ePHI [electronic Protected Health Information]..." Medical record review revealed Resident #81 was admitted to the facility on 11/11/16 and readmitted on 7/15/17 with diagnoses including Displaced Supracondylar Fracture with Intracondylar Extension of Lower End of Left Femur, Dyspnea, Chronic Obstructive Pulmonary Disease, Acute on Chronic Combined Systolic and Diastolic Heart Failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Atrial Fibrillation, Chronic Pain Syndrome, Heart Failure, Pleural Effusion, Gastroparesis, Hyperlipidemia, Panic Disorder, Major Depressive Disorder, Anxiety Disorder, Hypertension, Irritable Bowel Syndrome and Gastro-Esophageal Reflux Disease without Esophagitis. Resident #81 discharged from the facility on 7/28/17. Medical record review of the Quarterly Minimum Data Set dated 6/28/17 revealed the resident had a Brief Interview for Mental Status score of 15, indicating she was cognitively intact. Review of the facility investigation revealed a written statement from Certified Nurse Aide (CNA) #2 dated 6/27/17 "...I was shown a picture by [CNA #1]. It was an inappropriate picture of the resident in 408B. I also witnessed [CNA #1] showing the picture at the nurse's station one night & laughing about it..." Telephone interview with CNA #1 on 10/11/17 at 6:35 PM revealed she admitted taking a picture of Resident #81 while the resident was transferring	F 223	**2.**All residents have the potential to be affected by this practice. On 06.27.2017 all residents were interviewed by department heads utilizing Abuse Questionnaire. No concerns were identified. All residents received a skin assessment on 06.27.2017, no concerns were identified. All staff were interviewed nursing administration and Administrator regarding abuse and neglect using the Abuse Questionnaire. Interviews included any knowledge of incident. No new reports of abuse were identified. **3.**On 06.27.2017, 100% of staff trained Administrator and nursing administration on Abuse with completion of abuse competency test with 100% pass rate required. On 06.27.2017, 100% of staff were interviewed on abuse and neglect using the Abuse Questionnaire with no new findings. On 06.27 and	

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F 223	Continued From page 1 cell and /or smart phones while performing work tasks. Further, video and or pictures should not be taken of residents, PHI [Protected Health Information] and ePHI [electronic Protected Health Information]..." Medical record review revealed Resident #81 was admitted to the facility on 11/11/16 and readmitted on 7/15/17 with diagnoses including Displaced Supracondylar Fracture with Intracondylar Extension of Lower End of Left Femur, Dyspnea, Chronic Obstructive Pulmonary Disease, Acute on Chronic Combined Systolic and Diastolic Heart Failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Atrial Fibrillation, Chronic Pain Syndrome, Heart Failure, Pleural Effusion, Gastroparesis, Hyperlipidemia, Panic Disorder, Major Depressive Disorder, Anxiety Disorder, Hypertension, Irritable Bowel Syndrome and Gastro-Esophageal Reflux Disease without Esophagitis. Resident #81 discharged from the facility on 7/28/17. Medical record review of the Quarterly Minimum Data Set dated 6/28/17 revealed the resident had a Brief Interview for Mental Status score of 15, indicating she was cognitively intact. Review of the facility investigation revealed a written statement from Certified Nurse Aide (CNA) #2 dated 6/27/17 "...I was shown a picture by [CNA #1]. It was an inappropriate picture of the resident in 408B. I also witnessed [CNA #1] showing the picture at the nurse's station one night & laughing about it..." Telephone interview with CNA #1 on 10/11/17 at 6:35 PM revealed she admitted taking a picture of Resident #81 while the resident was transferring	F 223	06.28, 100% of staff trained Administrator and nursing administration on Cell Phone policy. On 06.27.2017, 100 % of staff trained by Administrator and nursing administration on Social Media policy. On 06.27 and 06.28.2017, 100% of staff trained by Administrator and nursing administration on HIPPA. On 06.28.2017, 100% of staff received training on Dignity, Respect, Customer Service.All new employees will be educated by Human Resources on Abuse and Neglect, Social Media, Cell Phone Policy during the New Hire Orientation. 4.The SW will conduct Abuse/Neglect Interviews with a random sample of residents with BIMS > 9 or higher and/or family members every week for four weeks, and then monthly for three months, reporting results to QAPI Committee for review and recommendation.	

2.1

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	445124	A. BUILDING _____ B. WING _____	10/11/2017

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F 223	Continued From page 2 from the bedside commode to the bed. It was unknown when this picture was taken. Further interview revealed the resident was not clothed from the waist down. Further interview revealed approximately 2 months later the CNA sent the picture to CNA #2 and denied showing the picture to any other staff. Interview with the Administrator on 10/11/17 at 4:30pm in her office revealed confirmed the facility failed to prevent abuse/exploitation for Resident #81.	F 223	Any identified concerns will be immediately reported to the administrator with follow up completed as appropriate. Department Heads will audit staffs cell phone compliance daily during room rounds, documenting on Room Rounds Form. Any concerns will be immediately reported to the Administrator/designee with Immediately action as required.	
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (I) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (Ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225	**F 225 483.12 (a)(3)(4)(c)(1)-(4)** **1.** On June 27, the Director of Nursing interviewed Resident # 81 and secured a statement regarding the incident and placed in the investigative file. 100% of staff were interviewed on 06.27.2017 by nursing administration regarding abuse and neglect allegation related to missing money with no new findings. Results were placed in the investigative file. Administrator, Director of Nursing, and Assistant Director of Nursing received training on Abuse Reporting and	

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F 225	Continued From page 3 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	Conducting Investigations on 06.27 and 06.29 by the regional consultants. 2.All residents have the potential to be affected by this practice. 100% of residents with BIMS > 9 and or family members were interviewed by social worker to ensure no unreported abuse with no new findings. 100% of staff were educated on abuse and neglect by nursing administration on 06.27 and 07.13 then administered an Abuse Competency Test with 100% pass rate. to ensure comprehension. Skin assessments were completed on 06.27.2017 by ADON on residents with BIMs of < or equal to 8 with no new findings. 3.Administrator, Director of Nursing, and Assistant Director of Nursing were trained on 6.27+6.29 regional consultants on Abuse Investigation and Reporting. Abuse checklist was reviewed and to be utilized in all investigations.	

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to thoroughly investigate 2 allegations for 1 resident (#81) of 5 residents reviewed for abuse. The findings included: Review of facility policy, Abuse Prevention Program, dated 1/19/17 revealed "...Once the Administrator or designee determines that there is a reasonable cause for suspecting abuse, the Administrator or designee will investigate the allegation and obtain a copy of any documentation relative to the incident..." Medical record review revealed Resident #81 was admitted to the facility on 11/11/16 and readmitted on 7/15/17 with diagnoses including Displaced Supracondylar Fracture with Intracondylar Extension of Lower End of Left Femur, Dyspnea, Chronic Obstructive Pulmonary Disease, Acute on Chronic Combined Systolic and Diastolic Heart Failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Atrial Fibrillation, Chronic Pain Syndrome, Heart Failure, Pleural Effusion, Gastroparesis, Hyperlipidemia, Panic Disorder, Major Depressive Disorder, Anxiety Disorder, Hypertension, Irritable Bowel Syndrome and Gastro-Esophageal Reflux Disease without Esophagitis. Resident #81 discharged from the facility on 7/28/17. Medical record review of the Quarterly Minimum Data Set dated 6/28/17 revealed Resident #81 had a Brief Interview for Mental Status score of 15, indicating she was cognitively intact.	F 225	4. The Nurse Consultant will audit all Reportable Events utilizing the Abuse Investigation Checklist to ensure Abuse Investigations are thoroughly investigated and reporting policy and checklist are followed for three months, then forwarded to QAPI Committee for review and recommendation.	

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F 225	Continued From page 5 Review of the facility investigation regarding abuse/exploitation of Resident #81 revealed no statement from the identified staff who took the picture or from Resident #81. Review of the facility investigation of an undated hand written document revealed "...Res [resident] reported to nurse that $80 was missing fr [from] wallet. It has been 2-3 days since she saw it..." Further review of the facility's investigation revealed 5 witness statements were obtained from staff. Interview with the Administrator on 10/11/17 at 4:30 PM in her office revealed the resident was having hallucinations when she reported the money missing. The Administrator stated the hallucinations worsened as the day progressed, resulted in the resident being sent to local hospital for evaluation. The Administrator confirmed no additional witness statements were obtained nor was a statement obtained from Resident #81. The Administrator confirmed she wrote the hand written document in the investigation. The Administrator confirmed the facility failed to thoroughly investigate 2 allegations of abuse/exploitation and misappropriation of funds for Resident #81. Interview with the Assistant Director of Nursing (ADON) on 10/11/17 at 4:45 PM in the conference room revealed the statements in the investigations were obtained by the Director of Nursing, the Administrator and the ADON. The ADON confirmed no additional statements were obtained from any additional staff, from the identified staff who took the picture of Resident #81 or from Resident #81 about either investigation. The ADON confirmed the facility	F 225		

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F 225	Continued From page 6 failed to thoroughly complete both investigations. The facility failed to obtain statements from staff who worked prior to the money being reported missing and from Resident #81 thus the facility failed to completed a thorough investigation of the missing money per the facility. The facility failed to obtain statements from the identified staff who took the picutre of Resident #81 and from the resident thus the facility failed to complete a thorough investigation of abuse/exploitation per the facility policy.	F 225		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278	**F-278 483.20 (g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED** **1**Resident #34 was scheduled and assessed by the Dentist on 10.13.2017. Care plan was updated by the Minimum Data Set Nurse (MDS) as needed on 10.20.2017 The Minimum Data Set (MDS) Nurses were trained on Section L, "Oral/Dental Status", on 10.24.17 by the Regional MDS Registered Nurse. **2**All Residents have the potential to be affected by this practice. Oral Assessments were completed on residents by the Licensed MDS Nurses by 10.20.17. Residents identified with oral concerns were communicated to the physician and	10/24/17

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F 278	Continued From page 7 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accurately assess the oral status of 1 resident (#34) of 20 residents reviewed. The findings included: Medical record review revealed Resident #34 was admitted to the facility on 3/31/09 and readmitted on 9/8/09 and 11/9/15 with diagnoses including Alzheimer's Disease, Abnormal Posture, Urinary Tract Infection, Autonomic Neuropathy in Diseases, Restless Legs Syndrome, Vitamin D Deficiency, Acquired Hemolytic Anemia, Anxiety Disorder, Major Depressive Disorder, Dementia without Behavioral Distrubance and Hypertension. Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/7/17, the Annual MDS dated 5/5/17, and the Quarterly MDS dated 8/2/17 of the Oral/Dental Status section revealed the resident had no concerns. Observation on 10/10/17 at 9:53 AM in the Main Dining Room, on 10/10/17 at 12:40 PM in the 600	F 278	dental appointments scheduled for follow up. Care plans will be updated as needed. 3MDS Nurses were trained by the Regional MDS Nurse on Section L, "Oral/Dental Status", on 10.24.17. The MDS Consultant will Audit 10% of Comprehensive MDS Assessments monthly for 3 months to ensure accurate coding effective 10.25.17. Any concerns identified will be immediately addressed with reeducation, correction and communicated to the Administrator. 4The MDS Consultant will Audit 10% of Comprehensive MDS Assessments monthly for 3 months to ensure accurate coding. Any concerns identified will be immediately addressed with reeducation, correction and communicated to the Administrator. The results of audits will be forwarded to the Administrator and Director of Nursing for review then forwarded to the QAPI Committee for review and recommendations.	

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F 278	Continued From page 8 Hall area, and on 10/11/17 at 7:20 AM in the 600 Hall dining area revealed Resident #34 had several missing front teeth at the top and bottom of the mouth. Interview with the MDS Corrdinator on 10/11/17 at 12:10 PM in her office revealed she was responsible for completing the dental status section of the MDS for Resident #34. The MDS Cordinator confirmed Resident #34's dental status section on the Quarterly MDS dated 2/7/17, the Annual MDS dated 5/5/17 and the Quarterly MDS dated 8/2/17 were not coded accurately.	F 278		
F 516 SS=D	RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS CFR(s): 483.20(f)(5)(i)(ii); 483.70(i)(3) 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to safeguard medical record information against loss or	F 516	**F-516 483.20 (f) (5)(i)(ii); 483.70(i)(3)** **RELEASE RESIDENT INFORMATION, SAFEGUARD** **CLINICAL RECORD** 1On 10.10.17 at 4:02 PM the Assistant Director of Nursing secured the controlled substance prescription and educated the licensed nurse on the policy for Controlled Substance Prescriptions emphasizing the importance of maintaining the security of the controlled substance prescriptions by placement of prescriptions into sealed envelopes for delivery to pharmacy. Education was also provide on ensuring the door to the nursing station is locked when licensed staff are not in attendance.	10/25/17

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F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	The HIPAA Policy was reviewed and the importance of securing resident information including the medical record was stressed with emphasis on always logging off of computers and never leaving a computer work station open when unattended. 2On 10.10.17 at approximately 4:30 PM an automatic lock was placed on the nursing station door by the Director of Maintenance. On 10.11.17 the maintenance director applied automatic door closure device to the door. 3All residents have the potential to be impacted by this practice. On 10.10.17 at approximately 4: 10 PM the Director of Nursing and Assistant Director of Nursing immediately conducted audits of all nursing stations and computers to ensure patient information, medical records, and prescriptions for controlled substances were secured properly. No concerns were identified. Facility staff were educated by the Director of Nursing and Assistant Director of Nursing on HIPAA Policy and the importance of maintaining the confidentiality of resident information including the	

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F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	medical record was reviewed. Logging off of computers and never leaving a computer work station open were emphasized. On 10.10.2017 and 10.11.2017 licensed nurses were educated by the Assistant Director of Nursing and Director of Nursing on the policy for Controlled Substance Prescriptions emphasizing the importance of maintaining the security of the controlled substance prescriptions by placement of prescriptions into sealed envelopes for delivery to pharmacy. Education was also provided to ensure the door to the nursing station is locked when licensed staff are not in attendance. The HIPAA Policy was reviewed and the importance of securing resident information including the medical record was stressed with emphasis on always logging off of computers and never leaving a computer work station open when unattended. 4The Director of Nursing or her designee during new Hire Nursing Orientation beginning on 10.25.2017 will provide education to nursing staff on the HIPAA Policy, with emphasis on maintaining	

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F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	security of resident information. Emphasis will be provided regarding security of the medical records, use of privacy screens for computers, logging off of computers and never leaving a computer work station open when unattended. Privacy screen protectors have been ordered for computers and will be applied to computer screens by 10.25.2017 to improve privacy of residents electronic medical records. Random audits will be completed by the Director of Nursing, Assistant Director of Nursing and the Manager on Duty on weekends beginning 10.25.2017 twice daily for two weeks, then twice weekly for four weeks then weekly for six months, to ensure HIPAA Compliance regarding controlled substance prescriptions, medical record security, use of privacy screens on computers and computers logged off when not in use. Any concerns identified will be	

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THE WATERS OF GALLATIN, LLC	555 EAST BLEDSOE STREET GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 516	Continued From page 9 unauthorized use. The findings included: Review of facility policy, Controlled Substance Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..." Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area. Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.	F 516	reported to the Administrator and Director of Nursing or designee and addressed immediately with staff reeducation and counseling as appropriate. The results of audits will be forwarded to the Director of Nursing and Administrator for review and follow up then forwarded to the QAPI Committee for review and recommendations.	

10.3

EMPLOYEE NAME	POSITION	ABUSE	CELL PHONE	SOCIAL MEDIA	HIPPA	STAFF QUESTIONNAIRE	DIGNITY, RESPECT, CUSTOMER SERVICE
Adams, Tierra	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Adams, Valaurie	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Adams, Virginia	DIETARY AIDE	6/27	6/27	6/27	6/27	6/27	6/28
Alguire, Lori	LPN	REFUSED	6/27	6/27	REFUSED	6/27	REFUSED
Ashworth, Tina	SOCIAL SERVICES	6/27	6/27	6/27	6/27	6/27	6/28
Blackwood, Sherrie	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Blake, Sarah	ST	6/27	6/27	6/27	6/27	6/27	6/28
Byram, Jana K.	DON	6/26	6/26	6/27	6/26	6/27	6/28
Byrd, Melissa	RN	6/27	6/27	6/27	6/27	6/27	6/30
Cantrell, Shelia	CLERICAL/PAYROLL	6/27	6/27	6/27	6/27	6/27	6/28
Chastian, Margie	LPN	6/27	6/27	6/27	6/27	6/27	6/29
Clay, Montrea	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Cook, Christie	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Cooper, Destiney N	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Copass, Phyllis	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Crain, Tony	MAINTENANCE DIR	6/27	6/27	6/27	6/27	6/27	6/28
Cross, Rita	TRANSPORTATION	6/27	6/27	6/27	6/27	6/27	6/28
Dabio, Mindy	OT	6/28	6/27	6/27	6/28	6/27	6/28
Dalton, Sharl	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Davenport, Jamie	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Dell'Aquila, Johnna	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Dixon, Madelyn Rochelle	OFFICE MANAGER	6/27	6/27	6/27	6/27	6/27	6/28
Douglas, Sonya	CNA	6/28	6/28	6/28	6/28	6/28	6/28
Esquivel, Jeannie	HSKP SUPERVISOR	6/27	6/27	6/27	6/27	6/27	6/28
Faulton, Lois	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Foshee, Jeniffer	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Getchel, Danielle	MDS	6/27	6/27	6/27	6/27	6/27	6/28
Gleaves, Jeraldean	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Gooch, Charla	LPN	6/27	6/27	6/27	6/27	6/27	6/29
Goostree, Kelsey	CNA	6/27	6/27	6/27	6/27	6/27	6/28

EMPLOYEE NAME	POSITION	ABUSE	CELL PHONE	SOCIAL MEDIA	HIPPA	STAFF QUESTIONNAIRE	DIGNITY, RESPECT, CUSTOMER SERVICE
Grissom, Bryan	PT	6/28	6/27	6/27	6/28	6/27	6/28
Grizzard, Janie	DIETARY AIDE	6/27	6/27	6/28	6/27	6/27	6/28
Gross, Kathy	DIETARY DIRECTOR	6/27	6/27	6/27	6/27	6/27	6/29
Haapala, Carrie	RSM	6/27	6/27	6/27	6/27	6/27	6/28
Haile, Peggy	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Hall, Darneka	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Haper, Linda	ACTIVITY AIDE	6/27	6/27	6/27	6/27	6/27	6/28
Harris, Ashley	DIETARY DIRECTOR	6/27	6/27	6/27	6/27	6/27	6/28
Harris, Lisa	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Haviland, Bonnie	COOK	6/27	6/27	6/27	6/27	6/27	6/28
Henry, Phillip	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Honeycutt, Carolyn Renea	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Hoskins, Christy	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Howard, Moffitt Verica	RN	6/27	6/27	6/27	6/27	6/27	6/28
Christian, Renard	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Humphrey, angelitio	COOK	6/28	6/28	6/28	6/28	6/28	6/28
Jenkins, Marchell	DIETARY AIDE	6/27	6/27	6/27	6/27	6/27	6/28
Joaque, Lucy	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Johnson, Dominque	CNA	6/28	6/27	6/27	6/28	6/28	6/28
Jones, Karen	MEDICAL RECORDS	6/27	6/27	6/27	6/27	6/27	6/28
Layne, Amy	LPN	6/27	6/27	6/27	6/27	6/27	Resigned 6/29
Layne, Tammy	CNA	6/27	6/27	6/27	6/27	6/27	6/28
[redacted]	PT	6/28 MAIL	6/27	6/27	6/28 MAIL	6/27	6/28
Litts, Vickie	RN	6/27	6/27	6/27	6/27	6/27	6/28
Locke, Bettye	MDS	6/27	6/27	6/27	6/27	6/27	6/28
Loftis, Robert	COTA	6/27	6/27	6/27	6/27	6/28	6/28
Long, Maria	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Malone, Burnell	REHAB AIDE	6/27	6/27	6/27	6/27	6/27	6/29
Manier, Donner	ACTIVITY DIRECTOR	6/27	6/27	6/27	6/27	6/27	6/28
Martin, Robin	CNA	6/27	6/27	6/26	6/27	6/27	6/28
McDonald, Anna	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28

EMPLOYEE NAME	POSITION	ABUSE	CELL PHONE	SOCIAL MEDIA	HIPPA	STAFF QUESTIONNAIRE	DIGNITY, RESPECT, CUSTOMER SERVICE
Mikkelsen, Erika	PT	6/27	6/27	6/27	6/27	6/27	6/28
Moore, Judy	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Morris, Cynthia Hasking	OT	6/27	6/27	6/27	6/27	6/27	6/28
Morrison, Sally	PTA	6/27	6/27	6/27	6/27	6/27	6/28
Newman, Ida	LPN	6/27	6/27	6/27	6/27	6/27	6/29
Overall, Danielle Lexie	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Overman, Judy	LPN	6/27	6/27	6/27	6/27	6/27	6/30
Peek, Elizabeth	CNA	6/28	6/28	6/28	6/28	6/28	6/28
Rand, Trevor	LPN	6/27	6/27	6/26	6/27	6/27	6/28
Reynolds, Jennifer	LPN	6/27	6/27	6/27	6/27	6/27	6/28
Roberts, Patricia	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Satterfield, Sharon	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Shelton, Dawn Michelle	COOK	6/27	6/27	6/27	6/27	6/27	[redacted] 6/30/17
Sisco, Angela	LPN	6/28	6/26	6/26	6/28	6/27	6/29
Smiley, Delia	ADMISSION DIR	6/26	6/26	6/26	6/26	6/27	6/29
Smith, Joyce L.	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Spencer, Lisa	PT	6/28	6/27	6/27	6/28	6/27	6/28
Sollinger, Kevin	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Steitler, Hannah	ST	6/27	6/27	6/27	6/27	6/27	6/28
Stevens, Jamie	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Stewart, Rita Annette	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Sweat, Jennifer	CNA	6/27	6/26	6/27	6/27	6/28	6/28
Thieme, Jennifer	DIETARY AIDE	6/28	6/28	6/28	6/28	6/27	6/30
Toney, Amy	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Wheeler, Amanda	CNA	6/27	6/27	6/27	6/27	6/27	6/28
Williams, Larry	PTA/TC	6/28	6/27	6/27	6/28	6/27	6/28
Williams, Pam	ST	6/28	6/27	6/27	6/28	6/27	6/28
Williams, Priscilla	LAUNDRY	6/27	6/27	6/27	6/27	6/27	6/28
Williams, Trina	CNA	6/27	6/27	6/27	6/27	6/27	6/29
Willmore, Robin	ADMINISTRATOR	6/28	6/28	6/28	6/28	6/28	6/28
Wood, Therese P	LPN	6/28	6/26	6/26	6/28	6/27	6/29
Woodard, April	HOUSEKEEPING	6/27	6/27	6/27	6/27	6/27	6/28
Yeagar, Laura	DOR	6/27	6/27	6/27	6/27	6/27	6/28

Staff Questionnaire

Staff Name: _____ **Date:**_____

1. **Have you or do you know if anyone has ever taken any pictures of a resident?**

2. **Have you or do you know of anyone posting residents pictures or information on any social media?**

3. **Have you ever witnessed any type of abuse toward a resident in this facility?**

4. **Have you or do you know of any staff member that has violated the Personal Health Information(PHI) policy in regards to any resident in this facility**

THE WATERS OF GALLATIN – In-Service Record

Date: 01.27.2017

Subjects covered:

Abuse investigation and reporting guidelines - 1:1 w Rick Mimnitz, RVP

PRINT NAME	SIGNATURE	TITLE	SHIFT
Robin Willmn	RWillmn	Admin	

THE WATERS OF GALLATIN – In-Service Record

Date: 6/29/17

Subjects covered:

Abuse reporting protocol

PRINT NAME	SIGNATURE	TITLE	SHIFT
Christy Hoskins		~~ADON~~	
Jana Byram	Jana Byram, RN	DON	

6/29/17